JOURNAL of MAINE EMS

JANUARY 2008

INSIDE:

BY JAY BRADSHAW, EMT-P
DIRECTOR MAINE EMS

The Test of Time

"Great things are not accomplished by those who yield to trends and fads and popular opinion."

- Jack Kerouac (1922 – 1969)

The statement that EMS is a fascinating, multi-faceted field should not come as a surprise to anyone on the mailing list for this Journal. The variety of calls and the unknown challenges that will come with the next call are limitless. Also seemingly limitless are the sheer number of gadgets, rumors, and so-called "research" that cause excitement for some and angst for others.

Those of us who have been around EMS for a while (and you know who you are) have seen the rise and fall of things like sandbags for head immobilization, the "jaw breaker" oral screw, EOA, and MAST. We've seen some things come, and go, and then return with new support (e.g. tourniquets). Others have come based upon "the literature", then leave as quickly when "the literature" was held up to the light of a new day. Remember the high dose epinephrine fad? Or Levofed? Fortunately for us, frontal lobotomies never made it to the prehospital arena.

Dr. Steve Diaz, Maine EMS Medical Director, has said several times that when he was in medical school, professors told him that 1/3 of what they were being taught would be proven wrong in time. The challenge is in trying to identify which 1/3 that will be – and often the test of time is full of surprises. Information presented as dogma transforms to dog scat.

That being the case, what should those of us who want to be informed and up to date do when confronted with the latest and greatest idea? Let me be so bold as to offer a few basic thoughts.

- Relax. If it's a really good product or idea, it will continue to grow and gain support. This isn't a race for who has what first. The first VCR was the Sony Betamax.
- Look at who is promoting the idea. Ask if the person making the presentation is affected by the success or failure of the idea/product. Be professional and polite, but appropriately skeptical and cautious.
- A nice full color brochure with bold quotes and pretty pictures is neither literature nor research. It is advertising. Advertising is not all misleading or bad, but it is understandably biased.
- Not all research is equally created or applicable. A paper built upon information from other papers could be valid, or it could be a house of cards. To help learn about the difference, talk with those you know who understand and can explain the differences. A hospital study based upon a specific subset of patients may not translate to the prehospital world. A pulse upon arrival at the ED is not the same as surviving until discharge. Read more than the abstract. It can be dry reading, but like oatmeal in the morning, it can also be good for you.
- Don't expect to be spoon fed. The most rewarding treasure requires some digging. Through this Journal and other sources, Maine EMS, the regional EMS offices, and many others will help provide a lot of information – but all that we can provide may only be the tip of the information iceberg. Fortunately there are numerous online and on ground resources available. It's worth your time to do the leg work – and if you find something really interesting, let us know. We are very thankful when this happens.

Of course all of the above logic only applies to EMS and not when you are trying to convince someone else in your household that a 37" HD LCD TV with a 5.1 Dolby surround sound system is a must have item. Hypothetically speaking, of course.

One Stop Shopping

In the months following the crash that killed Paramedic Alan Parsons and seriously injured EMT Arlene Greenleaf, there have been discussions with other public safety agencies about setting up a one-call system that will notify the appropriate agencies. Effective immediately, the Bureau of Labor Standards (BLS) will be that one call. During normal business hours, the number to call is (207) 623-7923. Evenings and weekends, call (207) 592-4501, E-mail: accident.bls@maine.gov

By statute, the Bureau of Labor must be notified within eight (8) hours of a work-related fatality and within twenty four (24) hours of a work-related hospitalization for public sector employees. Although private sector agencies are required to make their report to OSHA instead of BLS, BLS has offered to receive any of these calls, regardless of the corporate structure, and begin the subsequent notification process.

Colorful Journal

The new layout for the Journal of Maine EMS – with full color in the last issue – has been very well received. The credit for this goes to Melissa Arndt, Slingshot Multimedia, and Kelly Roderick, Editor. The Journal is also available on our web site, which is in the process of undergoing a major design overhaul.

As you have seen in the past and again in this issue, we also benefit from the contributions of many writers, photographers, proof editors, and advertisers. Without these there would be no Journal – and to keep it going, we solicit your participation. If you have a picture or article you'd like to submit for consideration, please contact Kelly Roderick (see page 2).

Best wishes for a safe and happy new year! See you in a few months.





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Cover photo by Jeremy Buzzell, EMT-P

Kennebec Valley News

KVEMSC Holds Annual Meeting
The KVEMS Education Committee and I have looked at the following information as part of our "Educational Plan" for 2008. Please stay tuned to the website and emails for specific dates for each. As always any suggestions or questions can be referred to me directly: brian@kvems.org.

Licensure Programs
2008 Paramedic Program (starts 1/18 and runs through Dec.)

2008 Spring and Fall Intermediate Programs (Spring starts 1/15 and runs through May. The Fall program starts the end of August and runs through Dec.) Please watch website for entrance exam date for Fall Class.

2008 EMT Classes:
Spring: Colby College Jan Plan, Augusta, KVCC, Litchfield, and Togus VA

2008 First Responder Classes:
Spring: China

MEMS 2008 Protocol Update
The regional office will be hosting several training session this coming year to prepare EMS Providers for the transistion with the new Maine EMS Protocols. Be watching for a full schedule.

Geriatric Emergency Medicine
GEMS "Canned" Program that gives providers specifics on the geriatric population and how to deal with them on a more direct basis. We have all seen a large increase in Geratic calls as our population ages. They like Pedi patients need special training to provide them with the specialized care they need.

MCI STEP-UP Training
Regionwide training will be offered to all providers to better prepare them for a possible MCI within their service or area. Remember an MCI is declared if your service has taxed its full complement of resources, so that is very different for all service. Your size and personnel count is a large factor in this. We all need to be prepared for regular MCI events as well as the BIG ONE...we all have tucked away in our minds.

ACLS for Basics
"Canned" Program that gives BLS Providers, "the what to expect" on that critical cardiac/stroke call, from the ALS Providers.

ALS Refresher
With the recent MEMS decision to test future Paramedic Candidates at the NREMT Level, we see a need for recertification training, as well as those that would like to get their NREMT certificate. This class will be a joint venture between KV and NEEMS.

KIDS SAFETY DAY
To celebrate EMS Week, we will be looking to do a joint project with Bike Safety, Seatbelts, and Car Seat Safety in areas of our region in May. If your service is interested in getting involved please let me know as we will start the planning process in January.

As always we are looking to book PHTLS & PEPP Programs in your area.

Inhalant Abuse: It's Right Under Your Nose

APRIL 2008 - DATES AND LOCATIONS TBD

Inhalant abuse is the intentional breathing of gases and solvents to produce a euphoric effect. According to the 2006 MYDAUS survey, 12% of Maine Students, grades 6-12, reported they have abuse inhalants. The goal of this training is to acquaint participants with the nature and patterns of inhalant abuse and provide them with effective prevention tools, messages, and resources. The brochure and registration form will be available in late February on the AdCare web site: http://www.neias.org/SATAdcal.html. If you would like a brochure and registration form when they are available in late February, email your request to adcare@neias.org or mail this form back to:

Jessica Gogan, Prevention Program Manager
AdCare Educational Institute of Maine, Inc.
75 Stone Street, Augusta, ME 04330

Name _____Organization_____

Street_____

City/State/Zip _____

Phone _____Fax_____

Email _____

Delta Ambulance Institutes
New Vehicle Marking Design
December 2007 • Waterville/Augusta
In the interest of safety, Delta Ambulance has begun instituting a new ambulance vehicle marking scheme.

As the new ambulances arrive, in addition to the Delta name and logo, they will be marked with a twelve inch blue and gold reflective band around the sides and rear of the vehicle. This band is broken by diagonal chevrons and a two color diagonal upright. The vehicle is also trimmed with white reflective, and has reflective chevron markings inside the compartment doors.

Our goal is to make the ambulance highly conspicuous, even when you are not looking for them. Studies have indicated that inattentional distraction can be lessened with the addition of irregular contrast reflectivity patterns. Emergency vehicles need to stand out, being easily distinguished from other vehicles.

We believe we have found the right balance - which is necessary... too much and it lessens the visibility of people and things near, too little and in certain low-light conditions the vehicle virtually disappears from view.

Irregular reflectivity patterns have been used successfully in Europe.

Delta has an excellent Safety record... approaching 500,000 personnel work-hours without a lost-time injury. We want to make additional gains.

Delta Ambulance is a not-for-profit paramedic ambulance service serving the communities of central Maine from bases in Augusta and Waterville. www.DeltaAmbulance.org.

Composite day/night view photo can be downloaded att www.deltaambulance.org/news/ambulance_markings_122007.jpg.

Additional photos may be viewed/downloaded at http://picasaweb.google.com/DeltaCR/DeltaAmbulanceNewAmbulanceMarkingScheme?authkey=oNH4Q_bZGKA.

Maine Ambulance Association Update

Geoffrey W. Miller, EMT-P
Secretary

The Maine Ambulance Association held its annual meeting on Wednesday November 7, 2007, in the Schooner Room at the Samoset Resort. Prior to the meeting, a round table discussion was held with officials from the Maine Bureau of Medical Services in response to questions asked by the MAA membership. The discussion was moderated by Rick Petrie of KVEMS and covered a wide range of topics.

Following the discussion, President Tim Beals called the annual meeting to order. He welcomed guests and new members by introducing the officers and directors and then gave a brief rundown of the achievements of the past year. These were primarily legislative and ranged from the successful effort to increase reimbursement for wheelchair van service to the addition of rate increases and cost reduction measures in federal legislation, which were unfortunately undone by a presidential veto of the SCHIP bill.

Other issues discussed included the current progress of the EMSSTAR study, the CPE or Rider A process (which has been suspended for the time being), and the need to find new and productive ways to interface with officials at the state and federal level to facilitate change in a manner that is less confrontational and more cooperative.

Elections were held and the current slate of officers was reelected for a new term. The officers and directors will be listed on the MAA web site soon along with the duration of their terms.

The meeting was capped off by a discussion on the inclusion of non-governmental EMS workers in federal line-of-duty death benefits legislation. This discussion ended with a decision to donate $1,000 to the Maine EMS Memorial fund in memory of Alan Parson who was killed in a tragic accident in Turner earlier this year.

The year ahead looks as busy as any other in our history. We encourage all EMS organizations to contact us and join in the effort to improve the state of the EMS industry in Maine. Visit us at our website www.the-maa.org.

Executive members and their contact information:

Timothy Beals, President : tbeals@deltaambulance.org
Dennis Brockway, Vice President : 1brockway@roadrunner.com
Geoffrey Miller, Secretary : pac@hypernet.com
Chuck MacMahan, Treasurer : cmcmahan@ahs.emh.org
Danny Carlow, Volunteer Non-Profit Rep : dancarlow@verizon.net
Dean Milligan, Municipal Rep : director@med-careambulance.com

MEMSRR Update

by Vicki Lincoln and Janet Purton

Electronic Run Reporting at Downeast EMS

Little did we realize sitting in a class on electronic run reporting back in 2006, that our lives as we knew them, would forever be changed. How are we ever going to sell this to our people? How are we ever going to get the 4 different bases that are at least 100 miles apart all trained the same way? Let alone the local hospitals we deal with on a regular basis. What do you mean do we have internet access in the ER? You've got to be kidding! High speed internet! What's that? Why do you need it anyway? Computers- we're going to be doing run reports on computers! You know I don't like working on them I'm lucky I can turn one on. These were some of the questions and hurdles we immediately were faced with when Downeast EMS decided to jump in with both feet and start the process of electronic run reporting.

While we were familiarizing ourselves with the MEMSRR site, so we could train our employees, we were also working with the three local hospitals we frequent daily and with whom we have wonderful working relationships. We first contacted the QA Nurses at each facility and after explaining the benefits of electronic reporting and that we would like to have internet access at the hospitals they sent us on to their I.T. departments. Fortunately Calais Regional Hospital had just built a new facility that had internet access throughout, so it only meant adding access to the EMS room. With the port installed, we had a generous donor donate a PC to place in the EMS room for all services to use. Calais Regional was on board and ready to go when we were. Downeast Community had internet access and PC's already in place in their library that they graciously made available to any service using MEMSRR. By having PC's on site at the hospitals it allowed our employees to enter their reports at the facilities, giving the hospitals immediate access. Houlton Regional has been going through some IT changes and will be able to down load our reports beginning November 1, 2007.

After many nights of training employees and with each given the task to complete 10 practice runs, we set the date to go live for June 1, 2006. Although we were nervous with such a big change we stuck with the date. It was imperative that we stayed steadfast and confident in the system. The crews did very well and over time have improved their entering times and understanding of the importance of accurate data input. We initially allowed the employees to use the MEEMS Run Reports as "scrap paper", but found they were still filling them out completely and then entering the run on MEMSRR. We took them away and gave them an almost blank piece of paper to record times, mileage, vitals and any procedure or medication given

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that could be left at the hospital in the event the report could not be entered immediately.

The reports we generated were great except we could only generate them for the individual not as a whole company. We contacted Image Trend and since we are unique in our structure and they had not had a service like ours before they created a special site (we call it our Super Duper account) so we can generate reports, as a whole, for our service.

All was smooth sailing…then we attended a class on the Field Bridge Version. How wonderful it would be if the employees could do their reports on the way to the hospital or on a transfer. With grant monies available through the State to assist in purchasing Panasonic Toughbooks and software licenses, going with the Field Bridge was within our grasp. With the support and approval of our Director and the Board of Directors, we were able to purchase 6 Panasonic Toughbooks. Upon their arrival we began the task of making sure they were all set up uniformly and that the information for the individual bases was on the correct Toughbook. Once the information is installed they are not interchangeable as each base has its own service license. As employees were trained they were able to use the Toughbook. They had become quite proficient in MEMSRR so the transition to the Field Bridge was not as "painful". Training only consisted of the "bells and whistles" of the Field Bridge software as the information that employees must input is 99% the same. We have been using the Field Bridge for a few months now and everyone (including us) has adjusted nicely. Our next hurdle will be to eliminate the remaining paperwork we are still gathering. Change is hard.

We would not be where we are today without the tremendous support and guidance we received from Ben Woodard and all the people (too many to list) at Image Trend.

KELLY RODERICK
EMSC CHAIRPERSON

Pediatric Resources

Recently State EMS Director Jay Bradshaw met with Dan Kavannagh, MSW, from the EMS for Children Health Resources and Services Administration for Maternal Child Health Bureau about our EMS for Children Federal grant. Arrangements have been made to have MEMS conduct a Pediatric Resource Survey of all services and hospitals in Maine to fulfill our data collection piece of this grant. Each year MEMS is asked to report on the various performance measures in order to remain compliant with the grant and this is one of those measures. The Operations Team (regional coordinators) agreed to work within their own regions to collect the data necessary for this survey. The data collected will assist us as a state to develop pediatric curriculums and equipment needs that will ultimately assist us in delivering better pediatric care to the citizens of Maine.

Your regional coordinator will be sent the survey tool and they will be making direct contact with each of their regional services and hospitals asking for a few moments of their time to complete the survey. It is our goal to have nothing less than 100% compliance on this project. As mentioned previously this is one of the leading performance measures with our grant and if we fail to complete this task to the federal government's standards we risk losing our EMS Funding for the coming year.

Some of the current project that are funded with EMS for Children funds are: Pediatric Education for Pre-hospital Providers (PEPP) programs to help offset the tuition; Inhalant Abuse Recognition training; EMS for Children Safety Day; Ryan Alert – Special Healthcare Needs training for EMS; Bike Safety, Playground Safety; Statewide Electronic Data Collection; Maine EMS Journal and many more regional projects.

Thank you all in advance for your help in collecting this data. Please make plans to meet with your regional coordinators and submit your data, as our deadline is February 2008. Again we are planning to have 100% compliance from all services and hospitals. Should you have questions regarding this EMS for Children project or other projects the Committee is working on you can reach your regional representatives:

Region 1 - John Leighton
Region 2 - Carmen Heatherington
Region 3 - Kelly Roderick
Region 4 - Sally Taylor
Region 5 - DeAngela Cyr
Region 6 - Steve Leach
Maine EMS - Jay Bradshaw

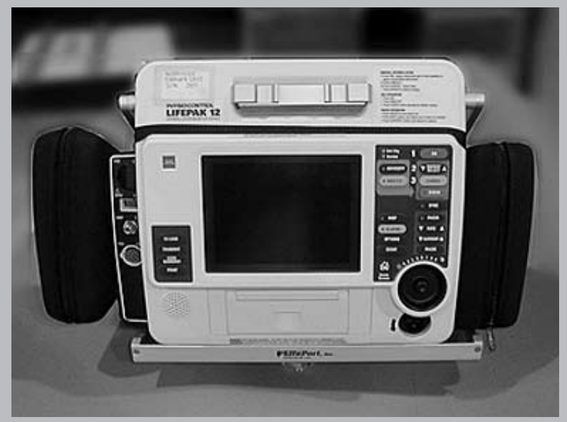
Southern Maine EMS News

Cape Elizabeth Rescue would like to donate 2 ---Life-Pak 12's to a service anywhere in the state that has a true need for a unit. These will be made available in mid- February 2008.

If your feel your service is deserving and could use a unit, please send a letter stating why your service is in need and why they should be selected no later than February 1, 2008.

Mail to:
Southern Maine EMS Council
496 Ocean Street
South Portland, Maine 04106
ATTN: Life Pak 12 project

Do not contact Cape Elizabeth Rescue directly.



The Ski Patrol

Eva Murray, EMT-B
Matinicus Rescue

When we think of emergency medical personnel, we think of EMTs and paramedics in ambulances, dispatchers in communications centers, often firefighters, emergency nurses and flight medics. We might think of local volunteer first responders, and perhaps the wilderness responders at various levels who are likely to be outdoor trip leaders and park rangers. There is another "branch" of EMS which might not come to mind...these are responders who do to a very large extent the same work, under often very challenging conditions, and who certainly deserve the same appreciation as the urban responder. They are the members of the National Ski Patrol.

Right now a few of you are sort of wrinkling up your noses, as if to say "Ski patrol? Be serious." Ski Patrollers are the medically trained rescuers, first aid staff, crisis managers and safety officials on the ski slopes. Though employed by ski areas (or sometimes volunteering in exchange for free skiing or discounts,) they are certified only after completing a rigorous and nationally consistent education program...they are not simply "workplace safety team members," nor are they qualified only in the eyes of some untrained ski area manager. The nation's 26,000 ski patrollers have completed a training program which is very much like the EMT-Basic curriculum, with somewhat more attention paid to outdoor environmental emergencies, and perhaps a bit less to internal medicine and geriatric care issues. Many are advanced EMS providers, firefighters, or other kinds of responders when off the slopes. As well as dealing with broken legs and hypothermia, patrollers must also be able to take vital signs and recognize the signs and symptoms of serious medical conditions, to interview ill patients, to react appropriately to life-threatening medical crises such as stroke, diabetic emergency, and of course cardiac calls, (and yes, their training program DOES include a bit on emergency childbirth!) As responders to the whole ski area, not just to the trails, they may be called upon to handle any problem at all.

The red National Ski Patrol jacket (more like a parka) is a badge of honor and evidence of a lot of hard work accomplished in the cold. It is the uniform worn by those ready to deal with anything that happens on the mountain, on the ski area access roads, and in the condominiums, from lost children, numb toes, and nervous skiers who find themselves "above their level," to horrible high-speed accidents resulting in death and dismemberment. Patrollers carry radios and some basic emergency equipment; they also make use of rescue sleds or toboggans loaded with splints and other stabilization equipment. More emergency equipment is located in the "top shack" and in a ski patrol base station near the main lodges and retail area. (This is also where patients with non-critical injuries are cared for; many patients can be treated right at the ski area.) Ski patrollers respond to and stabilize patients wherever they become injured, which generally means right in the middle of the ski area, with perhaps biting winds, perhaps dozens of less-than-helpful bystanders, perhaps icy, difficult slopes or wet, finger-numbing snow.

I am not trying to romanticize what they do; certainly it is not unlike what we were all trained to do. It is certainly no less, however, and nothing is made easy by the weather, the tourists, or the angle at which much of the work is done. Candidates are drilled in the priorities of scene safety, body substance isolation, patient consent and legal issues, and what is expected of a professional rescuer. All have taken CPR, of course, but many have training in such as avalanche rescue and other outdoor specialties. Although most of the patroller's calls will be handled in the same way as any EMT might do, a few concessions must be made for the conditions. One seasoned patroller whom I've known for years comments on the difficulty they have from time to time with "hospital EMS people," some of whom firmly believe that the weatherman knows or cares what it says in the protocol book. "Why is this patient still dressed? Why isn't this patient completely exposed?" demands the ambulance-minded professional. "Because it is ten degrees below zero outside," thinks the ski patroller. Yes, there is that.

The nation's 26,000 ski patrollers have completed a training program which is very much like the EMT-Basic curriculum, with somewhat more attention paid to outdoor environmental emergencies, and perhaps a bit less to internal medicine and geriatric care issues.

At Sunday River, in Newry, Maine, a Pace ambulance is ready and waiting to transport patients who require hospitalization on busy days such as weekends and school vacations; at other times, the ambulance is dispatched as needed. The EMTs in the ambulance, however, would be ill-equipped to get up the ski trail, stabilize and perhaps immobilize the patient in the snow, and get them down the mountain safely, quickly, and without scaring them out of their wits. Ski patrollers do not hesitate to backboard a patient high up on the mountainside, if mechanism of injury indicates a chance of spine injury, and to get that person down the mountain in the sled, carefully controlled by the patroller on his or her own skis, or snowboard.

Yes, snowboard. If you think snowboarders are all wigged-out, reckless adolescent hotshots, riding down stairway banisters and fence railings, living off energy drinks and daddy's trust fund, or flinging themselves off cliffs to catch big air doing some kind of Alleyoop Air-to-Fakey McTwist 720 whatever-it-is, think again, dude. That snowboarder might be the one taking expert care of you after your painful and frightening mountainside "yard sale."

Maine's Gould Academy, a four-year college-prep high school serving boarding and local students in Bethel, just a few minutes away from the Sunday River ski area, offers the only ski patrol training program for high school students in the country (at least now; word is there are schools elsewhere which are looking at Gould's 20-plus-year-old model to start similar educational programs.) In the Gould program, dedicated students can potentially graduate high school as "jacketed," meaning certified Ski Patrol members, welcomed at ski areas everywhere.

The Ski Patrol training program begins with students spending their first winter getting through the Outdoor Emergency Care course, which is very much like the EMT-Basic course with, logically, added emphasis on environmental and sports injuries. Much of what they learn could easily be applied to any outdoor or athletic setting; there are "mountain bike patrols" in a few places, for example. (I have had a good look at the textbook used for the OEC class, and I will vouch for the thoroughness of the program...it really is largely the same as EMT-Basic, so no more skeptical looks.)

Candidates practice skills such as patient assessment, immobilization and extrication both in the classroom and on the snow. After completing the course and passing the exam, which not everyone manages the first time, candidates spend a couple more winters helping and observing at the ski area...not informally "just hanging out," but instead, working through an exhaustive list of incidents and emergencies with which they must assist, and skills which they must demonstrate to instructors, to be "signed off" a certain number of times on each. It sounds as if these candidates get a good deal more experience than I had when I was first licensed as an EMT.

I asked some of the Gould students who are currently in the program how they became interested in this training; after all, taking the course means adding what is essentially another academic obligation during the afternoon sports time slot, it means committing to three or four winters of cumulative work to get jacketed, and it is no place for the irresponsible, the childish, the lazy or anyone unwilling to inconvenience themselves. They work in the bitter weather, they comfort the mildly injured and reassure the scared, they manage the panicked and the out-of-control, they deal with the crying, screaming, and shivering, they deal with the small child, the speaker of no English, the handicapped, the elderly, the intoxicated, and the insufferable snob, and they know that at any moment they could get called to deal with trauma, shock, cardiac arrest, or death. Stereotypes about the air-headed behavior of adolescents, their "it's all about me" attitude and their unwillingness to lift a finger for their fellow man, are certainly defied by the Gould Academy Ski Patrol members, jacketed seniors and candidates alike.

A few of the students I met had been ski racers or otherwise experienced skiers, and had observed over time what the Ski Patrol did. At least one had some first aid experience, but was a beginner skier (he learned quickly, and that's no small feat, because a patroller has to be confident enough not to be worrying about his or her own ability, or nerves, when somebody else is in trouble.) A couple spoke with obvious respect for the other members of the patrol candidate group, which influenced their decision to join. Free skiing can't hurt, but it is hardly the reason to join. These are very special kids.

As I spoke with one of the Gould students about his experiences as a new ski patrol candidate, he was telling me about his early days on the mountain. He began to tell the story of his first "code," and I immediately broke in with something like "Oh, I'm so sorry that had to happen, that's awful, it's so hard when one of your first calls

is a fatality." "What are you talking about?" he asked. "She messed up her ankle." It turns out that these ski patrollers call everything a "code," as in Code 1, meaning treat and release, up through Code 4, meaning immediately life-threatening. I guess there are a few differences!

A few end notes: I am not much of a skier, and I apologize to those who are if there's anything I should have described differently. Many thanks to Seamus, Nick, Galen and Eric, to El Jefe, Mr. Manning and Ms. Meslang at Gould Academy, and to Robin. There are a lot of good stories to tell and I'm hoping to do another article with patroller interviews and color photographs somewhere someday. I welcome input.

We joke that Matinicus is the only island in Maine with an active Ski Patrol, but when that small airplane crashed, it was George the ski patroller who skillfully checked out the passengers.

MAY GOD REST HIS SOUL!!

For the Heroes of Oklahoma City 1995

The Devil's lips screeched and the walls breeched.
His breath blew and the glass shards flew.
The Devil's hands clapped, supporting beams snapped,
And His black face ate the Sun.

Rivets spat from His tongue, like shots from a gun.
And the deadly flames grew, fed a chemical brew.
Electric cables were slashed, re-bar hashed,
Concrete slabs smashed, and bodies splashed.

All the babies were entombed
in their ground floor room,
Crushed flat on their backs on their naptime mats-
Nine floors collapsed in pan-caked stacks.

But the rescuers rolled before the first death knell tolled,
And the whole town started to run.
They Stood Tall at The Wall, where a concrete fall,
Like a wrecking ball, could crush them all.
They dug with their hands through the deadly sands-
Beyond engineer's plans, even God's demands.
Cutting torches flashed, as the heroes dashed.
Diamond drills bit and chewed fiber-optic cable slits.
Then they stopped to listen,
while the sweat glistened,
For a soft little breath,
on the brink of death.

A paramedic runs with a mother's dying son,
A Pieta begun under the smoking gun.
The Captain said "lock him in the rig, and be done!"
But she wasn't the one, to leave her job undone.

She did just what she was told- but ever so Bold-
She locked the door and laid on the floor
And held him tight in the dawn's eerie light,
While his blood pooled, and his body cooled.
Then the most feared shout:
From the Scene Commander- "Pull out!
If the cribbing gives, no one lives-
And no comfort to the dying gives!"

As the flashlights fade, victims in voids laid,
Sense the coming of the Shades, as they start to invade.
Their Worlds start to spin- death spirals of Original Sin.
But soon he screams, with transfixed grin, "Everybody back in!"

After three days straight, the rescue dogs paced.
Scent trails were traced but with only Death traces,
They laid down sad-faced, frozen in place as if disgraced,
Until live bodies placed, so they could lick warm faces,
Renewed their Faith in Life over Death in concrete encased .

The devils entrails were impaled on red hot nails,
His Blackness paled beside our Patriots' tale-
That rides the rails on into Forever.
"We will never fail!
We'll All ride to the Very End of the Trail
To lift Death's Veil from America's Holy Grail.

They all saw God's face in that horrible place,
felt showered with grace, in His loving embrace,
And fulfilled His plan to help them stand
Tall for Our Land- Heroes of The American Clan!
So this is an ode to The Honor Code and the Mother Lode
Of Good In a World where the awful taste
Left by Evil's haste, and young lives' waste,
Has been replaced by God's shining helmet and mace.

Paul Averill Liebow, MD, FACEP

Do We Really Know What We Are Doing Out There?

Greetings, Colleagues! As I stated last issue I haven't written regularly in the Journal since doing so as State EMS director ten years ago. I now have the privilege and pleasure of pursuing an on-going mix of EMS system development projects from evaluating local EMS needs and services, to evaluating state EMS systems and serving as Maine's part-time trauma manager, to being a consultant for several federal agencies and writing papers and books, or pieces of books, for national associations.

This column on issues at the national level is called "National VS" (Vital Signs) to remind me to avoid BS and keep it at the street-level of interest at which we all work.

I will try to offer a column for upcoming Journals on issues at the national level that impact or will impact Maine EMS providers now or in the near future. It's called "National VS" (Vital Signs) to remind me to avoid BS and keep it at the street-level of interest at which we all work.

Remember the last 10-55 you were on? How'd it go? No, really! Think so? Did you feel 100% safe on the roadway at all times? Were police, fire and EMS responders well coordinated from the moment each arrived? Did each have clear expectations of the others' roles during the critical first minutes? So, really, how did it go?

Generally, I think we get the job done in reasonable fashion, particularly on smaller roadways. But unless you are in one of a handful of departments that preplans traffic incidents with police and fire colleagues (typically those responding to "the 95's" and similar roadways) you probably respond in medical-tunnel-vision mode which is not in the best interest for you, your patients, or others at or driving by the scene.

Your priority is getting the rig as close to the patients as possible, hopefully remembering to position it for efficient departure, and then you dive on the patients (or wait until they are made available to you). Right? I know that is pretty much what I do and see. And our police and fire colleagues have their own tunnel-vision perspectives as well. With experience, we develop informal sets of expectations about what everyone is likely to do and, as I said, we get the job done without killing anyone.

A couple of years back I had the privilege of being asked to serve as the EMS guy on a multi-disciplinary team sent to Europe by the federal government to look at how traffic incidents are managed in four countries: England, Germany, the Netherlands, and Sweden. The experience really opened my eyes to how much better we could do at crash scenes. In fact it had such an impact on all of the team, that it has resulted in adoption of something called the National Unified Goal ("NUG") for traffic incident management here in the US. More on that later.

figure 1

While over there, I had a chance to look at neat EMS toys and practices as well. I let figure 1 speak for itself! Well, go East young man (or woman)…to England! These are used to get around in thick traffic.

In Germany, medics stay safer buckled into in swiveling "captain's chairs". Next time you sit in the typical CPR seat, take a look to your left. There is probably a cabinet at head height and an open space below it. In filmed studies of ambulance crashes in the US, dummies lose their heads when hurled to the left in a sudden vehicle deceleration. The same studies show clearly that our bench seats cannot be made safe even with seat belts and "medic-catcher" netting.

figure 3

Also in Germany, we saw a much safer set-up which patients and medics prefer (Figure 3). The cot and a wheeled chair both have lift-assist devices for getting them into and out of the vehicle. Both lift-assist devices firmly lock the stretcher and chair into the floor, making them highly resistant to tearing free in a crash. The same ambulance crash tests show wheeled cots in American ambulances breaking free from mountings in some instances and cutting off the medic in the captain's seat at the head of the patient right at the shins. Ouch! I now never ride in the CPR seat without staying in a ducked position, or in the captain's chair without positioning my legs to the side of the cot.

Ninety percent of the patients the German fellows pictured here transport go in the chair, not the cot. They and their patients prefer it, they reported.

Finally, my Dutch friends pictured in Figure 4 are both nurses. To attain an EMS ALS field position, they must have four years of nursing education,

one year of experience in an ER or ICU, then one year of full-time EMS training and a year of internship. Their LifePak 12 may not be remarkable nor, in and of itself, the thrombolytic drug in the carton next to it. What is different is that they administer it purely on the LifePak 12's interpretation of the 12 lead they obtain. They produced Dutch research showing that this is an acceptable method and gave me the book. Unfortunately it is in Dutch, so I reserve judgment!


figure 4

Well, back to traffic incident management. One of the things we observed in three out of four countries visited, was a strong national commitment to effectively orchestrated traffic incident management. In fact, in the Netherlands it has become the law. Now, like a 60% income tax rate and socialized medicine, we may not be fast to nationally imitate such European concepts, but we certainly have something to learn here.

The Netherlands' "national directive" on traffic incident management (TIM) states five priorities that must be observed in the following priority order:

1. Worker safety
2. Traffic safety
3. Assistance to victims
4. Maintaining flow
5. Salvaging cargo/vehicle

Getting more specific, the Dutch include as TIM responders: EMS, police, fire, highway authority, and towing/recovery and all TIM responders are trained and held to the same expectations for initial response, regardless of who is first on scene. These expectations include:

1. Placing their vehicle in "fend off" position 100 yards back, protecting the scene;
2. Placing traffic cones in a precise pattern fencing off the scene and safe traffic flow;
3. Once the scene is safe from traffic, providing patient care (all TIM responders must have at least first aid).

At this point, as other responders arrive, they begin to assume their traditional roles. For instance, if EMS arrived first and placed the ambulance in "fend off" position, it would be replaced later by a police or other vehicle and moved to a position where it could easily depart the scene.

Other conventions of the Dutch model include (for major roadway incidents, applicable as determined necessary on smaller roads):

1. Police, EMS, fire, and other TIM response leaders gather for a brief planning session once all are on scene to discuss features of how they will proceed;
2. Only the emergency vehicles at the ends of the scene, and those coming in or departing, have their emergency lights onto cut down on confusion and glare;
3. Quick response by highway authority portable message signs and "rubber-necker barriers" (which attach to guard rails -- Figure 6) are assured by their location and staffing throughout the country.


figure 6

Finally, vehicle and personnel visibility is a high priority. Figures 7 and 8 show examples of what we experienced.


figure 7


figure 8

A version of the markings on the back of the ambulance in Figure 7 will soon become a standard in the U.S. for fire vehicles. There is now a standard for TIM responder vests in the U.S. For more on both, please visit www.respondersafety.com, an excellent website on the subject.

Adopting such common sense procedures in the U.S. is unlikely to happen on a national basis, given that we are so "states' rights" driven. Recognizing that, the National Traffic Incident Management Coalition (NTIMC – see the websites at http://www.transportation.org/?siteid=41&pageid=591 and http://timexchange.org/inc/inc.nsf/home), an organization of public safety and other national associations dedicated to better traffic incident management, has created the "National Unified Goal for TIM", or "NUG", to which I referred earlier. Over two years, the NUG took shape with nationwide input. It has now been endorsed by all NUG members including the National Association of State EMS Officials, the National Association of EMTs, the International Association of Fire Chiefs, and the International Association of Chiefs of Police.

The NUG is organized around three major objectives:

- Responder Safety
- Safe, Quick Clearance
- Prompt, Reliable Incident Communications

The NUG promotes achievement of these objectives through 18 strategies listed at the NTIMC website. Key strategies include development of multi-jurisdictional, multi-disciplinary TIM policies, procedures and training; and development of national, multi-disciplinary recommended practices for many operational issues related to TIM. The goal is to adopt local and statewide "Dutch-like" response coordination policies.

I encourage readers to take the lead in their communities to get to know the NUG and start discussions about establishing these practices. A very good source of sample practices, agreements and other materials to use in this local effort can be found in the "Quick Clearance Toolkit" developed by the I-95 Corridor Coalition. These may be found at http://www.i95coalition.org/quick-clearance-toolkit.html.

Finally, a simple poster has been developed by NAEMT to highlight some of these practices. It is available for free download at the Responder Safety website mentioned above (see Figure 9). Note the use of cones and fend-off positioning, as well as the reflective vest.

So, no excuses now, go forth and heal, but let's be safe out there!

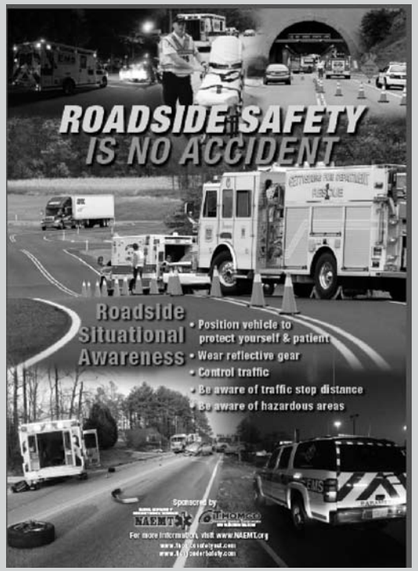
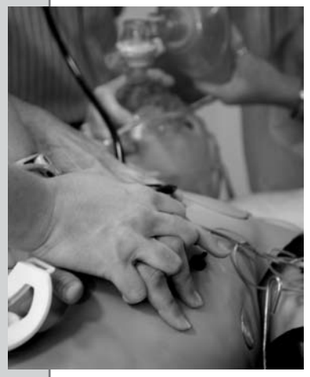


figure 9

Hands-On Training OPPORTUNITY



Starting in the spring of 2008, regional EMS services can request onsite training with the Human Patient Simulator (HPS) program. The HPS, purchased with funds from the 2003 state transportation bond and owned by Maine EMS, is a mobile training lab designed to provide advanced emergency medical education to providers at all levels of care. The program started in 2006, visiting all the hospitals in Maine and offering 90-minute sessions of team-based training to any interested EMS and hospital providers. The program was very successful in most areas, and now that awareness has been raised, the HPS is ready to expand its services and make its hands-on training opportunity available to EMS groups across the state.

Since it is impractical to drive the gas-guzzling RV to every local EMS service in the state, we are looking for groups of services from one region to get together and make a request for 2-3 days of focused emergency medical training. LifeFlight of Maine crew members facilitate the training and have created an array of pre-programmed patient scenarios that can be used. If services have a specific training need, the team can also develop patient scenarios specific to that need.

For more information on this one-of-a-kind opportunity, contact The LifeFlight Foundation at 207-785-2288 or visit our website at www.lifeflightmaine.org.

The EMD Corner

Drexell White, EMT-P
Maine EMS EMD Coordinator

Since January 1, 2007, Maine's EMS system has grown by 40 licensed services and over 500 licensed providers. But unlike many of the other 285 services and 5,000+ EMS providers in Maine, the new services have no ambulances or response vehicles and the newly licensed personnel provide EMS care from behind a communications console. The newest members of the Maine EMS system are the emergency medical dispatchers and EMD Centers that provide emergency medical dispatch for the thousands of medical 9-1-1 calls received every year in Maine.

Emergency Medical Dispatch is a systematic approach to processing medical calls that includes standardized questions, pre-arrival instructions and prioritization of EMS resources and response. EMD is not new to many dispatch centers in Maine, having been adopted over the years by the centers as a way to improve the way 9-1-1 medical calls are processed and EMS providers dispatched. The most significant change in recent years came as a result of Legislation passed in 2005 requiring licenses for all Maine Public Safety Answering Points (PSAPs) and Maine dispatchers, who perform EMD functions. The Legislation also identified Maine EMS as the State agency responsible for oversight of the new EMD system including training and instructor approval, protocol approval and Quality Assurance oversight.

With the inclusion of EMD in Maine's EMS system, pre-hospital emergency care for all 9-1-1 medical calls can now begin within seconds of a caller dialing the phone. Emergency Medical Dispatchers, using Maine EMS approved pre-arrival instructions (PAIs) can instruct callers on how to open an airway, perform CPR, control bleeding or deliver a baby, to name but a few of the scripted PAIs in the EMD protocols. Emergency Medical Dispatchers can (and have been proven to) increase the likelihood that when responders arrive at a scene, they will be confronted with a viable patient vs. one that has received no care prior to EMS' arrival.

Maine's EMD system is barely a year old and like all new systems, there have been and will continue to be growing pains. To help guide the system, the Maine EMS Board has added an Emergency Medical Dispatch Representative to the Board and has created the Maine EMS EMD Committee as a standing committee of the Board. The committee meets the 3rd Thursday of most months at Maine EMS in Augusta.

In coming installments of The EMD Corner, I'll include news of interest about Maine's EMD system and the Emergency Medical Dispatch professionals that work in the system. Please forward your comments and topic ideas to me at drexell.r.white@maine.gov

In the meantime, I urge all EMS providers to welcome EMD into the system: get to know the dispatchers in your area, learn more about the roles and responsibilities of emergency medical dispatchers, include EMD centers and personnel in continuing education training and establish an effective communications process between your EMS service and your EMD center.

Maine Emergency Nurses Association

Tammy Lachance, RN, BSN, CEN
Central Maine Medical Center

Annual Meeting and Education Day 2007
On September 7, 2007, Maine ENA held their Annual Meeting and Education Day at Maine Medical Center in Portland.

The educational theme was the management of the cardiac patient in the emergency department setting. Topics included "MI and Thrombogenesis" by Roland Auger, RN, BSN, CEN, "Congestive Heart Failure and Management" by Dr. Jonnathan Busko, "Holding the Ventilated Patient" by Sean Shortall, RRT-NPS, RPFT, "Insertion, Interpretation, and Management of Central and Arterial lines in the ER" by Patrick Weaver, RN, BSN, CEN, and "Cardiomyopathies and Management of LVADS" by PJ Colosimo.

The 2007 Maine ENA Annual Awards were presented during the brief business meeting:

Excellence in Clinical Practice Award ~ Megan Landry
Special Merit Award ~ Emma Gierczak
Educational Scholarship Award ~ Michelle Gosselin

Congratulations to the recipients of these awards!

Thank you to everyone who helped to make the Annual Meeting and Education Day a success. As always, it was an educational day filled with interesting discussion and great company!

SAVE THE DATE:
WINTER MEETING & EDUCATION DAY 2008
January 18, 2008 at Maine General Medical Center in Waterville

THINKING AHEAD: The 2008 Maine ENA Awards
Do you work with a spectacular emergency nurse? Someone who deserves a little credit for their talents and efforts? If so, nominate them for a Maine ENA Award!

Watch for the "Call for Nominations" in the Spring 2008 Maine ENA Newsletter or contact Karen Taylor, RN, Chairperson of the Nominating Committee, at taylokd@mmc.org.

ENA-Sponsored Courses
Emergency Nurses Pediatric Course "ENPC" - 2008 Dates - Check the Maine ENA web site at www.enamaine.org or contact Carmen Hetherington, RN, Pediatric Committee Chair, at carmen@suscom-maine.net.

Trauma Nursing Core Course "TNCC" - 2008 Dates - Check the Maine ENA web site at www.enamaine.org or contact either Trauma Committee Co-Chairs Geneva Sides, RN at sidesboss@hotmail.com or Amber Murphy at ambrmurphy@aol.com.

TNCC has been updated for 2008! The new provider course and materials will be available in March 2008. Instructor courses will also be available. So, if it's been a while since you've taken TNCC, now is the time! Topics included in this revision are a new chapter on disaster management, the inclusion of RSI in the airway education, and the return of helmet removal. Check out TNCC on the ENA website, www.ena.org, for more information about the new course.

Injury Prevention
Are you interested in providing injury prevention education? Please contact Sarah Scott, Maine's "EN Care" Coordinator, at sascott19@aol.com.

Maine ENA website
The Maine ENA web site is getting a face-lift! Coming soon -- the new and improved Maine ENA web-site at www.enamaine.org. Check it out!

Have a warm & safe winter!
Please wear a helmet when riding an ATV, snowmobiling, skiing or snowboarding!

From the I/C News editor…

Greetings all!

I write this editorial after having spent the better part of last weekend at the Samoset Resort for this year's Mid-Coast EMS annual conference. As always, there was so much to learn, so much to do, so many people to catch up with. While I could not be there for as long this year as I have in the past, I still had the opportunity to take some very exciting courses, a couple of which were I/C-related. It was good to have those to choose from, and I hope more I/C's will think about ways they can offer continuing education to their fellow instructors at future conferences.

And that leads me to a suggestion. I'd like to start incorporating an article that could be a source for Category 7 (I/C) credits in each upcoming issue of this newsletter. Would any of you would be willing to submit credit-worthy material? Nobody would have to commit to writing something every month, because if everybody contributed just one article over the course of his or her career in EMS education, we'd have enough material to fill every single issue. Please give it some thought, and if you have any ideas or questions, call or e-mail me.

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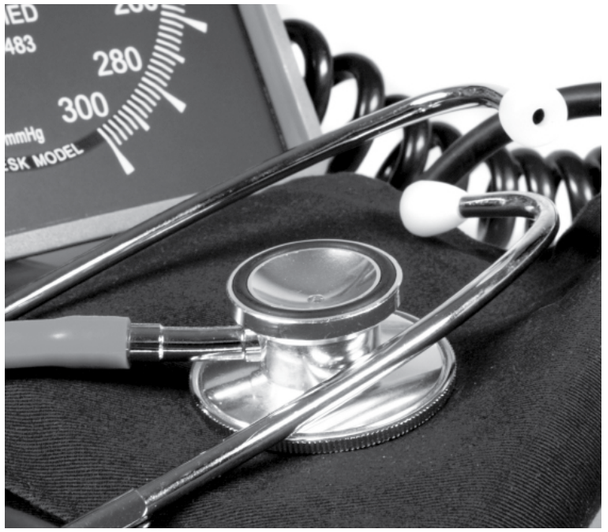
I recently updated my I/C News e-mailing list. I now have addresses for 63% of MEMS' I/C's. My goal is to get an address for everyone with e-mail. Remember that I don't give or sell your addresses to anyone else, and I only use them for I/C-related mailings. If you have not been receiving notices from me, please send me a quick e-mail (jackyv@vaniotis.com) with your preferred e-mail address.



EMS Education Standards

John E. Leighton, Jr., EMT-I, I/C, EMD,
I/C SMEMS EMS-C Coordinator

The new Education Standards process provides you with the opportunity to be part of the next generation of EMS education. Feedback from instructors like you helped develop the second draft, now on the www.nemses.org website for further comment. Click on "Draft Standards" and go to the bottom of the screen to view the latest. You can send comments directly to the principals involved in the project. The site continues to be a great source for all information on the project.

Teaching Tips

We have all had students who tell us that they have difficulty reading. All course administrators have policies for dealing with people who have documented disabilities, but what about those students who don't qualify as having a reading disability, but still have difficulty reading and/or writing? One thing you might suggest is that they make an audiotape of highlights of each chapter in their textbook as they read it. They can then listen to those tapes in the car, at work, while walking, and so on. If they want to, they can even record (or have someone else record for them) entire chapters from the textbook. They can then listen as often as they need to in order to help with their comprehension.

Minkler Joins EMS Magazine

Marc Minkler, a Portland firefighter and paramedic who has taught in the paramedic programs at York County Community College and Southern Maine Community College, is now a regular contributor to EMS Magazine. His column is called "Advanced Skills Lab."

If you go to www.emsresponder.com/interactive and click on the EMS Magazine "Monthly Insider" link, then scroll down to the June 2007 entry, you will see a link to a podcast where he discusses his goals for this magazine series. If you do listen to the podcast, there's also a link there where you can leave a comment for him.

State News

MEMSRR Electronic Run Reporting

Ben Woodard reports that instructors are beginning to teach electronic run reporting in their classes, using the web-based State Bridge system available at www.memsrr.org. He says the next step for them would be to incorporate the Tablet PC-based Field Bridge software.

Ben will be looking for instructors to teach MEMSRR in 2008. Be watching the next I/C News for more information on how you can become involved.

Regional News

AREMS

Steve Corbin, EMT-B, Regional Coordinator, Region 5

Aroostook EMS started an I/C program that began at the end of October at Northern Maine Community College. Although initial enrollment numbers were low, the regional office was impressed to see a few new faces, people who are interested in dedicating themselves to the future educational needs of EMS students throughout the region.

With an active I/C base, we will be able to continue to conduct licensure programs in local communities, where volunteer recruitment is especially needed in a rural area such as Aroostook County.

Over the past few years, we have been very successful at reinstating local BLS level programs. These programs tend to attract good candidates for ALS programs, and are the heart and soul of rural pre-hospital care.

Dan Bahr: Making a Difference

If you walk into the lobby of the Harold Alfond Center for Cancer Care at MaineGeneral Medical Center, you will see a plaque on the wall bearing the face and words of Maine EMS instructor and paramedic Danel Bahr. Dan, now the Business Administrator at County Ambulance in Ellsworth, is a five-year cancer survivor who used the same skills he uses for motivating students to successfully motivate and educate an entire community about the need for a cancer treatment facility. His efforts (along with those of many others) to help MaineGeneral convince the Central Maine area that it was needed, resulted in the opening of the cancer center in July of 2007.

In a recent conversation, Dan described what his experience with cancer has meant to him. He says that surviving cancer gave him a "second chance." The first thing he did after he was sufficiently recovered from his treatments was to go back to school and finish his college degree in Community Health Education. This had been a long time but long put-off dream of his, and the cancer experience made him realize he could no longer put off his dreams.

Dan has been using his education as well as his professional and personal experiences to help educate people about cancer, and to raise funding for cancer research and related programs. He's also committed to educating EMS providers and anybody else who will listen about cancer.

He says, "several years ago, in a joint statement from the American Cancer Society and the American Heart Association, it was recognized that cancer is the leading cause of death for Americans up to the age of 80, and continues to be such today. After the age of 80, cardiovascular disease finally catches up. As an EMS instructor, it is my duty to pass that information along to EMS providers. It is astounding to me that the leading cause of death of most Americans is not addressed in our EMS courses, from First Responder up through Paramedic level. I would ask everyone involved with EMS delivery in Maine how much education they received in their licensure courses about dealing with cancer patients and their families? You know the answer to that question. I'm on a mission to change that."

If you would like to discuss Dan's "mission" or to find out how you can help him or he can help you, you can leave a message for him at County Ambulance in Ellsworth, (207) 667-8569 or e-mail him at danbahr@roadrunner.com.

Committee Briefs

Education Committee

Daniel Batsie, EMT-P, I/C, Maine EMS Education Chair

In 2007 the Maine EMS Education Committee focused on large projects such as the Paramedic Interfacility Transfer Module (PIFT) and 12-lead ECG. In 2008, we hope to focus our time on a new vision for the structure of EMS education in Maine.

12-Lead ECG will continue to be on our plate for the foreseeable future. The work that has been completed has created learning objectives to guide all new, primary educational programs and has revised the state paramedic curriculum to mandate that 12-lead ECG be taught. What remains however, is to continue work to facilitate the teaching of programs so that every ALS provider in Maine has a competent, working knowledge of this critically important topic.

In the immediate future, the Education Committee will play a large role in the 2008 protocol update roll out. Our committee has already completed a review of the proposed changes and submitted to the MEMS Operations team an assessment of the educational impact. Once these changes are finalized, we will begin work on a statewide educational package designed to introduce the necessary learning associated with the changes. Discussion on this topic will be ongoing.

The 2008 buzz word however is "vision." In the coming year, the Education Committee will attempt to update the manner in which EMS courses are approved and monitored and take them from a one-time, quick review to a process that requires consistent quality and continued oversight. Although it is not exactly a correct term, we refer to the new process as accreditation.

We began our work by bringing up to date the current Maine EMS course approval standards. In doing so, we identified and updated the areas that we feel are the most important aspects of a licensure class and we will use these critical components as the beginning of a common standard. In modeling ourselves after a variety of other healthcare fields we will then look to develop a process that will enable MEMS to assure that any sponsor of a MEMS licensure course can continually meet the expectations detailed in the finalized standard. We will look not only at the original capabilities of the course sponsor but also at outcomes and ongoing capabilities to provide quality education.

What exactly this process will look like is unclear at this point. This is a complex endeavor that will require a great deal of input from a variety of sources. Our hope is to work with the MEMS staff and the Operations Team to develop a draft plan in the coming year.

As always, there will be other projects and issues that require our attention throughout the year. Our goal is to continue to work for quality EMS education in our state and our agenda will always be crowded with issues that lead us down that path.

Finally, I would like to address a concern I heard at the Maine EMS Town Meeting at the Mid-Coast EMS Seminar. At the meeting, a provider voiced his concern that MEMS committees were dominated by paramedics from large services and that the voice of the "little guy" often went unheard. Although I personally do not believe this is true, I would like to make sure it is clear that the Education Committee meetings are open to all those who would like to attend. The meetings occur on the second Wednesday of each month at 0930 at the Public Safety Building in Augusta. We continually look for guidance from all levels and from representatives of services of all types. We recognize that not every provider can attend a monthly meeting but please remember there are alternatives to attending. Polycom video conferencing is available from a variety of Maine hospitals and Regional Offices would be glad to represent your opinions. Please also feel free to e-mail me directly. Diverse input is critical to our success and we will make every attempt to hear your voice.

Exam Committee

By Jacky Vaniotis, RN, NREMT-P, Chair, MEMS Exam Committee

The Exam Committee has finished updating the Intermediate written exam, which is the only state licensing exam that MEMS currently maintains. As with most detailed projects, it took us longer than we had hoped, but by the time this issue of the I/C News goes to press, the 2007 version of the Intermediate exam should be in use. The next item we anticipate tackling, which we will do jointly with the Education Committee, will be a review of the EMT-Basic IPE process.

It has recently come to our attention that there is a misconception in the community that the Exam Committee is run by the National Registry. We wish to set the record straight: the Maine EMS Exam Committee is run by members of the Maine EMS community and answers to the MEMS Board. There is no National Registry representation on the committee, nor does the National Registry have any authority to direct the Exam Committee.

[continued on next page]

Computer Corner

Tracking Changes in Word

If you ever use the "Track Changes" tool in Word, you need to know that, if you should e-mail or otherwise electronically share your document, the recipient (and anybody else he or she forwards the document to) can view the changes and/or comments you have made, even if you have changed the view to "Final." This can prove to be very embarrassing if you've written comments that you wouldn't want anybody else to see, written inappropriate material and later thought better of it, or written other better-to-be-kept-private ideas that you later removed.

In order to clear out all the comments and changes, you need to accept or reject each and every change in the document. This is the only way to eliminate them entirely from the possibility of being viewed by somebody else. Turning off "Track Changes" does not eliminate the comments, and anybody else opening your document will still be able to see the changes. Microsoft provides instructions for how to do get rid of revisions once and for all: To get rid of tracked changes and comments, you need to accept or reject the changes and delete the comments. Here's how:

1. On the View menu, point to Toolbars, and then click Reviewing.
2. On the Reviewing toolbar, click Show, and then make sure that a check mark appears next to each of the following items:
   - Comments
   - Ink Annotations (Word 2003 only)
   - Insertions and Deletions
   - Formatting
   - Reviewers (point to Reviewers and make sure that All Reviewers is selected.)

   If a check mark does not appear next to an item, click the item to select it.
3. On the Reviewing toolbar, click Next to advance from one revision or comment to the next.
4. On the Reviewing toolbar, click Accept Change or Reject Change/Delete Comment for each revision or comment.
5. Repeat steps 3 and 4 until all the revisions in the document have been accepted or rejected and all the comments have been deleted.

Note: If you know that you want to accept all the changes, click the arrow next to Accept Change, and then click Accept All Changes in Document. If you know that you want to reject all the changes, click the arrow next to Reject Change/Delete Comment, and then click Reject All Changes in Document. To remove all comments, you must delete them. Click the arrow next to Reject Change/Delete Comment, and then click Delete All Comments in Document.

You can get these and more details on getting rid of tracked changes by going to http://office.microsoft.com/en-us/help/HA010983881033.aspx.

Favorite Blogs and Web Pages

I asked instructors to direct us to some of their favorite blogs and/or web sites. I got the following four from Larry Torrey, with commentaries:

http://ambulancedriverfiles.blogspot.com/index.html

Kelly Grayson, a medic from Louisiana, an author, and recently popular on the EMS lecture circuits.

http://jbontherocks.blogspot.com/

Jeff Brosius, used to work as a medic for Grady Hospital in Atlanta, now a flight medic in the Midwest. A rock climber in his spare time (explains the title).

http://urbanparamedic.blogspot.com/

Jay Weaver, a current and long-time Boston EMS medic and, incidentally, a practicing attorney on the side.

http://thelawdogfiles.blogspot.com/

A good read for anyone in public safety.

Dan Limmer has a blog at http://emergencymedicaltechnician.blogspot.com/. A recent entry includes a link to a video called "Life after Death by PowerPoint," a humorous look at PowerPoint presentations.

Please write with the addresses of your favorite blogs, e-groups, e-lists, and web sites relating to EMS and EMS education.

Exam Committee *[continued from previous page]*

At the October 16th meeting, we welcomed the two newest additions to our committee: Jeff Regis is joining us as the SMEMS representative, and Sally Taylor is joining us as the NEEMS rep. At that meeting, the committee also voted unanimously to change our regular meeting date from the second to the fourth Tuesday of each month. This change was made to accommodate changes in MEMS staff availability.

Please feel free to attend any meeting of the Exam Committee, which meets now on the fourth Tuesday of each month at 9:30 a.m. at the Maine EMS offices in Augusta. As always, we recommend that you contact MEMS before coming to make sure a meeting has not been canceled or rescheduled.

MAINE EMS I/C NEWS

In My Opinion

MEMA Disaster Exercise Program Overview

Mark Belserene, EMT-B; State Exercise Coordinator
Maine Emergency Management Agency

In the last edition of the I/C News, comments were expressed regarding EMS participation and Homeland Security funding in disaster exercises in Maine. This article highlights some of the efforts ongoing to meet the challenges discussed by Commander Carter.

Maine Emergency Management Agency (MEMA) has a great partnership at the county level and a deep history in planning, conducting and supporting disaster exercises. This relationship reaches back to the 1950's. From evacuating the entire City of Bangor during a Cold War era exercise, through the Maine Yankee days, to the present Homeland Security Exercise and Evaluation Program, MEMA has partnered closely with all response disciplines including EMS.

The primary goal of the state's Emergency Management Exercise Program is to provide an avenue for all emergency responders, specialty rescue, emergency management, healthcare, state and local administrators and support personnel to achieve a level of experience when managing a large, hazardous, extended and complex emergency scene. To reach this goal we utilize a strong emergency management, incident management, planning, interoperability and mutual aid system in addition to public/private partnerships.

The exercise program provides technical, planning and training support to state, county and local EMA offices and response agencies. This is performed in a variety of ways that include day-to-day support, budget development, meeting facilitation, planning assistance, exercise evaluation and trainings associated with exercising.

After the exercise is completed, the work continues through the After Action Review Process (AAR). This follow up is performed by implementing improvements to correct deficiencies noted during the exercise conduct. This may be achieved by additional training, drilling or exercising and can include the revision or correction of a written plan or other response activity. The AAR is part of an overall Corrective Action Program (CAP) that leads exercise participants to continually improve response capability.

The exercise program utilizes Homeland Security funds and has also included the purchase of MCI trailer units located through out the state. Additional funds have also been used for radios, AED's, training and other equipment specifically for EMS and victim rescue.

In the past two years, some full scale exercises planned and conducted at the county level have included: a large plane crash incident at Bangor International Airport, outside Brunswick Naval Air Station and the Portland Jetport, passenger train explosion with radiation release in Wells, helicopter crash with chemical release in Fryeburg, dirty bomb in Limestone, wildfire in the Pittsfield area and a statewide hurricane exercise, in addition to many others.

Some areas identified for improvement for EMS have included state protocol for an MCI (staging, treatment, transport areas etc.), and communications and ICS integration into unified command structure.

Several services are now exploring some regional planning issues. Tri-County EMS has been successful in establishing regional EMS plans that address mutual aid response and coverage for an MCI. Also there is a continuing focus on public health crisis such as pandemic influenza.

The staff at MEMA and county EMA's realize that "one size doesn't fit all." We spend countless hours trying to bridge the gap between learning ICS and NIMS, and then stepping up at a major incident. The answer is the same as it is for maintaining all EMS skills, "practice makes perfect." In the next year we plan to offer many smaller tabletop exercises to help practice new skills and procedures.

If you are looking to become more involved with planning and exercising with your service contact your county EMA office.

Mark Belserene is the State Exercise Coordinator for Maine Emergency Management Agency. Mark has been a licensed EMT since 1980 and a MEMS Instructor/Coordinator since 1992.

Last Words

Please submit any materials you would like to have published in the next issue of the I/C News by February 1, for publication in the April edition of the Journal of Maine EMS. Submit material to: Jacky Vaniotis, 172 Haskell Road, North Yarmouth, ME 04097, or email JackyV@Vaniotis.com

Maine EPIC

EMERGENCY PHYSICIANS INTERIM COMMUNIQUE

JOHN SAUCIER, MD, EDITOR | MAINE MEDICAL CENTER

New members

There have been a lot of emergency physician transitions over the last few months. Not only have their been changes in physician coverage of ED's within the state but we are also happy to welcome many new members to Maine. The following is a list courtesy of Anna Bragdon, Maine ACEP's executive director. Please let Anna know of any corrections that you might have at maineacep@roadrunner.com:

Maine Medical Center
Residents:
Daniel J. Britton, MD
Sadie J. Carter, MD
Thomas S. Cochran, MD
Thomas E. Ewing, MD
William "Doug" D. Gregorie IV, MD
Eric Moore, MD
Alexis A. Motti, MD
Hamilton Wells, MD
Attendings:
Megan Fix, MD
Samir Haydar, DO

MaineGeneral – Augusta
John Raymond Joseph, MD, FACEP

York Hospital
Scott Paige, DO
Amy L. Wyatt, DO, FACEP

Southern Maine Medical Center
Kimberly A. Perrault, DO

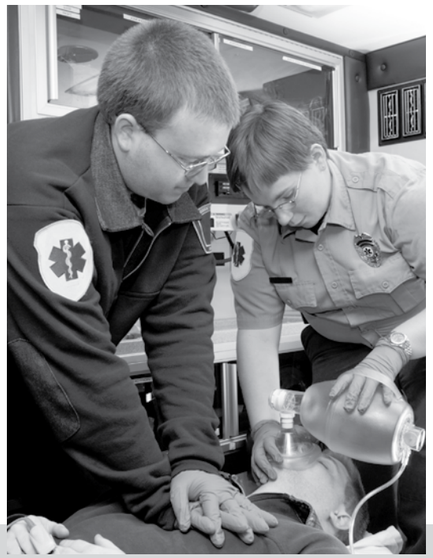
Midcoast Hospital
James B. Mullen, III, MC, FACEP

No Hospital Designation Given
George Cancel, MD
Victoria Powell, DO

Medical Student Members
Carl E. Barus
Travis DeVader
Kendra Emery
Melissa LeBorgne
Scott McQuilkin
Jen Palminteri
Lauren Schuler

Conference of Note

The 26th annual Maine Winter Symposium will be held at Sugarloaf from February 26 through 29th, 2008. This years speakers will be representing 4 different hospitals throughout the state. Topics will again be wide ranging from billing and coding issues to current pediatric problems and finishing with the ABEM required 2007 LLSA. We welcome Carl Germann of Maine Medical Center as this year's program director. Although Carl is only a few years out from his residency he brings both enthusiasm and experience in conference coordination that all attending will truly enjoy. We hope to see many of you there to enjoy skiing, learning and camaraderie. Registration discounts are available for Maine ACEP members, PA's, NP's, and RN's as well as a special one-day rate for those desiring to take only the LLSA review.



THE RESIDENTS CORNER

ERIC LOWE, MD, CHIEF RESIDENT
MAINE MEDICAL CENTER EMERGENCY MEDICINE

Learning From Far-Off Colleagues

Imagine trying to do your job, whether it be on an ambulance or in an emergency department, without the benefit of the supplies and equipment we take for granted on a daily basis. For example, think of trying to stabilize, diagnose, and treat a simple fracture without splints, x-rays, or casting material. Now imagine being the patient and not having the benefit of a modern EMS system. Think of the pain and difficulty of having to travel three hours in the back of a pick-up truck over rutted mud roads to reach a hospital after a traumatic accident without those splints or bandages. Unfortunately this situation is more reality than imagination for many of our colleagues who live and work in less advantaged places.

I am writing this column on the plane returning from a trip to Haiti, where I was fortunate to join a group of emergency personnel helping to evaluate the needs of an emergency department of the Justinian University Hospital (JUH) in the town of Cap Haitian. We traveled there as part of a delegation from Konbit Sante (www.konbitsante.org), a NGO begun and still centered in Maine, which has developed a longitudinal partnership with JUH. As one of the poorest nations in the world, Haiti routinely ranks among the lowest levels for many standard indices for health and public welfare, and functioning emergency care on a whole has been near non-existent but is now a target for improvement.

We spent time touring the department where physicians and nurses treat patients with an amazing scarcity of resources. Imagine working in a hospital that has had no x-ray facilities for years and has only water with fecal contamination to use for patient care.

In a Haitian hospital, physicians and nurses treat patients with an amazing scarcity of resources. Imagine a hospital that has had no x-ray facilities for years and has only water with fecal contamination to use for patient care.

In our system we have the luxury of having paramedics relay 12-lead ECG findings in from the field, yet at JUH, the whole hospital is without a functioning ECG machine. The ED itself has only a single neb machine with one mask, a semi-functioning suction machine, and some simple bandages, gauze, and laceration repair tools. At home, when taking medical control calls, I know I have well-trained teams on the other end who have specialized medications and supplies on hand, yet we saw ambulances equipped with only a bare stretcher and staffed only by a driver who has received no medical training and told us he often cannot find gloves to use in patient care.

The stories staff and patients relayed to us were often heart-wrenching and hard to grasp, yet one consistent theme our visit left us with was that staff were still providing relatively impressive care with the resources available to them. Much like we all do when we run up against the limits of our better equipped, yet still far from perfect, system, they continue to do the best they can in each situation for the patient in front of them. Medication prescriptions were adjusted to what was currently available, donated supplies and resources were used when available, patients were sent many kilometers away for x-rays after initial evaluation when needed, and wounds were still washed and closed with care. Seeing the state of the medical system our colleagues in Haiti are working with first-hand reinforced for me the luxury of the bounty of resources we practice with, yet it also reinforced the fact that we are all still working to do what we can for the patient with the resources with which we have to work.

Quality in EMS

What are we really talking about?

William H. Dunwoody, MBA, CQIA, CMQ/OE, EMTP

About 2,500 years ago, the Babylonian Empire was a leading power in the world. Even at this early time in the evolution of human civilization, many of the principles of quality management in healthcare that are used today were in common practice. If a physician made a mistake in the delivery of patient care and this care resulted in the death of the patient, the fix was simple; the physician's hands were removed with the swift blow of a sharpened sword. No we don't literally remove the hands of a provider anymore, be they physician, nurse, EMT, or paramedic, however, this practice is frequently used in a figurative sense more than we like to acknowledge. When something goes wrong, the easiest, most common approach and the most human response are to assign blame. This blame is usually assigned to the individual most closely associated with the procedure that failed—the individual responsible for patient care.

An effective quality management system requires participation from all levels of the organization.

Assigning blame to an individual for an action that has already occurred does nothing to resolve that situation and little to prevent future incidents from happening. The only thing that is accomplished when blame is assigned as part of an alleged quality management practice is to teach the individual that is the focus of the action and others that become aware of the action to fear the quality management system and its administrators. The act of assigning blame can be as far reaching as bringing the provider up for review with the appropriate regulatory agency or something as simple as singling the individual out for remediation, re-education, or some other form of probationary action. An effective quality management system requires participation from all levels of the organization. Can it be expected that a system that causes fear of retribution will elicit voluntary and honest participation from EMS field providers?

In its simplest form, health care is a system where inputs or raw materials such as a sick or injured body, medical supplies, and medications are processed in a hands-on approach using the human brain, low tech and high tech equipment, and the hand-eye coordination skills of an individual to produce

the output of a human body in an improved or at least no less degraded condition. The main problems with health care are that the processing of the raw materials is usually managed by a human being and the main raw material, the sick or injured patient, has unpredictable, variable responses to the processing function. Humans are notoriously prone to error for many reasons. The human brain has a limited capacity for the storage and processing of information and the management of bodily functions required for the delivery of competent medical care. Environmental factors and situational factors can have a huge impact on the ability of the human brain to perform its required functions. Add an argument with a significant other, an unexpected financial burden, lack of sleep, or a missed meal to the mix and the human's capacity to perform in an efficient and effective manner can be significantly impaired.

So what does this all mean with respect to quality management? Administrators and participants in the quality management process need to understand that health care providers are human, not super-human. The practice of assigning blame for performance deficits must be abandoned and modern principles of quality management must be adopted and implemented in all areas of system design, measurement, analysis, improvement, and control. Instead of focusing on improving people the focus must be shifted to improving the systems in which people operate.

According to Dr. Don Berwick of the Institute for Healthcare Improvement, "Every system is perfectly designed to achieve exactly the results it gets." This statement is supported by significant research and expert opinion in the quality management body of knowledge. What Dr Berwick is saying is if a healthcare system is producing poor outcomes in the delivery of patient care, look at the design of the system, the underlying causes of the failures or deficits to understand the reasons for these poor outcomes.

The basis for an effective quality management system is information and planning. The information required consists of an understanding of the organization's mission, vision, and goals, an understand of the organization's customers; who they are and what are their needs or values, and finally an understanding of the organizations key functions that fulfill the mission and achieve the goal of meeting or exceeding the needs of the customer. The second element that makes up the basis of an effective quality management system is planning. This consists of planning standard processes

for the treatment of patients and establishing systems that prevent patient or employee injury or death. In the clinical domain, these key functions and standard processes consist of practice protocols that are supported by research and recognized standards of care. This section of the quality management system is considered a prospective (forward looking) element.

Another important element of an effective quality management system is the measurement of performance. Performance measurement is intended to identify trends in the operation of planned system functions. The practice of measurement is the least understood element of quality management. It is the most visible element and is often used as the only component in some quality plans.

While there is usually some assessment of individual functions, measurement in quality management does not mean inspection. Inspection is the process of looking for defects in individual elements of a process. For instance, inspection of a patient care record may identify deficits in documentation but it gives no indication of what actually occurred during the care of the patient and does nothing about improving the care of future patients. Measurement should consist of determining, through statistical analysis, if trends in the patient care documented are present or emerging in the system. The measurement section of the quality management systems is considered a retrospective (backward looking) element.

Many organizations in the Maine EMS system are attempting to build a process of quality management using metrics based on identified key clinical functions; also know as focused studies. In this perspective a key clinical function is considered any function that is important to the overall outcome of patients with specific conditions. For instance, it has been shown through several clinical trials that patients with chest pain of a suspected cardiac origin have better outcomes if they receive early administration of aspirin. A study on if and how aspirin is being administered can be an important and pertinent analysis of how the Maine EMS system is impacting the outcome of patients suffering from chest pain of suspected cardiac origin. In most quality management programs around the State a problem emerges, however, when deficits in system performance are identified.

As mentioned earlier, the collection of system performance metrics is only one step in the quality management process. The next step is to identify the true causes of the deficits that are observed and to develop processes to rectify these deficits. Unfortunately, the most common corrective action employed is to implement an individualized, organization-, region- or State-wide education program to reintroduce a provider or multiple providers to the proper method of caring for patients with the condition specified in the focused study. This practice of jumping to a practitioner focused cause has multiple impacts.

Providers of care learn to mistrust a system of assessment that continually finds blame with the quality of care they provide. This leads to a decreased incentive to participate or to be honest in bringing personal needs, mistakes, or deficits to the forefront. In addition, it is rarely the case that the operators of a system are the true root cause of system failure. W. Edwards Deming, one of the fathers of quality management stated in his Theory of Profound Knowledge, "Every worker has unlimited potential if placed in an environment that adequately supports, educates, and nurtures a sense of pride and responsibility. Eighty-five percent of a worker's effectiveness is determined by their environment and only minimally by their individual skills. Management is responsible for creating the appropriate environment." If this is true, then 85% of the time deficits in the delivery of care should have some cause other than the knowledge and skill of the provider of that care.

Another issue that emerges when focus is immediately placed on the practitioner; there is little motivation to perform the work necessary to identify the true cause of the deficit. An effective quality management system is a lot of work and requires a commitment from the organization's leadership to provide the resources necessary to operate efficiently. Each and every participant in the organization also has to have a commitment to the process of quality management in order to have a favorable impact on improvement of the system's ability to delivery value to the organization's customers and to produce good patient outcomes.

The first step in the transformation of quality management into a process of effective design/planning, measurement, analysis, improvement, and control is to learn how to use the time tested tools and techniques of quality management that are available to anyone willing to do a little research, take a class, and adopt a new way of thinking. This is one of the objectives of this article; to get EMS managers and providers thinking about how to improve the system and to do it in a manner that results in good outcomes; outcomes for our patients, our organizations, our employees, and our health care system. It is time to bring EMS and health care into the 21st century with regard to its approach to quality management and system improvement.

Future articles will explore specific information about these tools and techniques as well as present case studies on current projects. Stay tuned.

Bill Dunwoody is the Director of Systems Development and Analysis for Delta Ambulance. He is a national leader in health care quality management and holds certifications and leadership positions in the American Society for Quality Healthcare Division.

SAVE ~~ THE ~~ DATE

Wednesday, March 19, 2008

Traumatic Brain Injury: Field to Rehabilitation ~ The Team Approach

Verrillo's Conference Center : Just off Maine Turnpike Exit 48

This special one-day program that will focus on the recognition, the assessment and the treatment of traumatic brain injuries. The program will provide an overview of these focused areas from the perspective of the certified Athletic Trainer, the Emergency Medical Services provider, the Emergency Department and hospital, and the Rehabilitation Team and the importance of an integrated continuum of care for the patient.

The morning plenary session will provide the basics from each discipline. The afternoon will feature four 2-hour breakout sessions focused on the more detailed care for each specific discipline.

The afternoon plenary session explores the new techniques that are or soon may be available for the care and treatment of traumatic brain injured patients.

Presenters will include: Neil K. Carroll, BS, NATC, PES; Doug Patey, NREMT-P, Maine IC; Beth Burke, OTR/L, CBIS; Julie Ontengco, NP, EMT-P; and Dr. David Ciraulo, DO.

We are proud to have as our luncheon speaker:

TRAVIS ROY

Watch the Southern Maine EMS website (www.smems.org) for final details and registration materials.

Medicare/Medicaid Compliance

Is Your Service Ready for an Audit?

Alan J. Azzara, JD, EMT-P
Vice President of Human Resources and General Counsel
North East Mobile Health Services

Several years ago, while attending a national EMS conference, an attorney told me about an audit that his client, a private ambulance service in a Midwestern state, had been through. The auditor from CMS (Center for Medicare and Medicaid Services) had come in to see run reports and other documentation related to a series of ambulance transports to and from dialysis centers.

Following a detailed review of the run reports, the examiner then turned his attention to the topic of Medicare compliance and asked the service director to produce documentation regarding the service's Medicare Compliance program. My attorney friend stated that his client appeared puzzled. Having just produced more than a hundred run reports, the service director thought he had shown the examiner everything that was required. The examiner was not impressed and ran down a list of items that he wanted to see. The audit went badly from there and the end result was the imposition of several thousand dollars in fines, along with a warning to develop an effective compliance plan within the next 60 days or risk being dropped as a Medicare provider.

While almost all EMS services in Maine are Medicare and MaineCare providers and bill for services provides to those patients covered by those programs, I'll bet that very few of these services are ready for a compliance audit and would do no better than the service referred to above. The purpose of this article is to provide a general overview of the basic elements of an effective compliance program.

Background

Over the past years the OIG (Office of the Inspector General) has identified numerous cases of abuse and fraud within the ambulance industry with respect to billing for Medicare and Medicaid. In response to these findings, written guidelines were published that outlined the elements of an effective Compliance Program. Though the publication did not specifically state that each of and every element was required, it did state that these elements would be deemed "acceptable as the building blocks of an effective compliance program." See Federal Register, Vol. 68, No. 56, March 24, 2003.

Elements of an Effective Compliance Program

The following are the elements identified by the OIG:

1. Policies and Procedures---The ambulance service should develop a series of polices and procedures that reflect a commitment to compliance and the elimination of abuse. Policies should address areas such as employee screening, review of run reports, billing review and staff reporting of potential abuse or fraud. These policies should be reviewed and updated on a regular basis and should reflect changes in the law and rules.
2. Compliance Officer---The service must appoint someone who will serve as the Compliance Officer. This person will assume responsibility for the development and implementation of the service compliance program.
3. Training---A key element of any compliance must include training of your staff on Medicare and Medicaid compliance. Training should take place for every new employee as part of orientation and should be repeated annually for all staff. Attendance should be documented.
4. Internal Monitoring---Procedures must be developed and implemented that will enable the service to identify issues of potential abuse and fraud. This should include, at the very least, run report and billing form reviews, audits of medical necessity documentation and inquiries to determine that all necessary signatures have been obtained.
5. Remediation Plan--- A plan must be developed that establishes the manner in which findings of potential fraud or abuse are handled. This may include a number of things such as re-billing, return of improper payments, reclassification of services provided (such as changing ALS to BLS) or, in the extreme case, referral to law enforcement.
6. Staff Reporting---Procedures must be in place that enable staff to report potential fraud or abuse to the compliance officer. This should also include a means of anonymous reporting for those employees who may not feel comfortable being identified or are fearful of retaliation.
7. Disciplinary Standards---Policies must be developed that provide for disciplinary action for those employees who either negligently or intentionally violate company policies of state or federal rules regarding delivery of services to Medicare or Medicaid recipients or billing for such services.

While there are many more things that can be done in the area of compliance, the foregoing will provide your service with a basic program that will meet the minimum requirements set forth in the guidelines of the Office of the Inspector General and will provide a reasonable level of protection in the event that your service is audited. Any EMS service that fails to take these basic steps does so at its own peril and exposes itself to potential fines and other penalties.

Maine EMS

Awards Nomination Form

Nominee's Name _____ Phone Number_____

Address _____

Nominee's Service Affiliation (if any) _____ Years of Service to Maine EMS Community_____

Nominee's Job Title_____

Nominator's Name _____

Address _____

City _____ State_____Zip_____Telephone_____

Please provide a description of the nominee's qualifications (your reason for nominating them)

_____

_____

_____

_____

_____

_____

Please provide 2 additional references who can attest to the qualification of the nominee

Name_____ Phone Number_____

Name_____ Phone Number_____

Please feel free to enclose a letter describing the nominee's qualifications and attributes in detail. All nominations must be received by the Maine EMS Board Awards Committee no later than March 15, 2008 at:

Maine EMS | Attn 2008 Awards
152 State House Station, Augusta, ME 04333
Email: maine.ems@maine.gov or Fax: 207-287-6251

MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	Ron Jones, EMT-P	23 Sterling Drive, Westbrook, ME 04092	TEL: 854-0654
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	James McKenney, EMT-P	229 State Street, Presque Isle, ME 04769	TEL: 768-4388
Tri-County EMS Rep	VACANT		
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Bill Montejo, RN, EMT-P	363 River Road, Bowdoinham, ME 04008	TEL: 666-3093
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
For Profit Service	Joseph Conley, EMT-P	11 Deer Hill Avenue, Standish, ME 04084	TEL: 642-5854
Not For Profit Service	Carol Pillsbury, EMT-P	PO Box 200, West Farmington, ME 04992	TEL: 778-6951
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	VACANT		
Municipal EMS Service Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	
Public Rep	VACANT		
Public Rep	Oden F. Cassidy	RR 2, Box 960, Houlton, ME 04732	TEL: 532-3941

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Regional Coordinators and Medical Directors

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TEL: 741-2790 | FAX: 741-2158 | smems@smems.org

REGION 2 — Joanne LeBrun, Tri-County EMS Council — Dr. Kevin Kendall, Medical Director
300 Main Street, Lewiston, ME 04240
TEL: 795-2880 | FAX: 753-7280 | lebrunj@cmhc.org

REGION 3 — Rick Petrie, EMT-P, KVEMS Council — Dr. Douglas Boyink, Interim Medical Director
71 Halifax Street, Winslow, ME 04901
TEL: 877-0936 | FAX: 872-2753 | office@kvems.org

REGION 4 — Rick Petrie, EMT-P, Northeastern Maine EMS — Dr. Jonnathan Busko, Interim Medical Director
EMCC, 354 Hogan Road, Bangor, ME 04401
TEL: 974-4880 | FAX: 974-4879 | neems@emcc.org

REGION 5 — Steve Corbin, Aroostook Maine EMS — Dr. Jay Reynolds, Medical Director
111 High Street, Caribou, ME 04736
TEL: 492-1624 | FAX: 492-0342 | aems@mfx.net

REGION 6 — Bill Zito, Mid-Coast EMS — Dr. David Ettinger, Medical Director
Thompson Community Center
Routes 131 and 17, PO Box 610, Union, ME 04862
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